Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00000

CERTIFICATE OF DEATH

Reg. Dist. No. 7 00001

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH:

01 COUNTY ALLEGANY — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND

LENGTH OF STAY (in this place): 23 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 SACRED HEART HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE WEST VIRGINIA COUNTY MINERAL

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RIDGELEY

857-3

STREET ADDRESS (If rural give location): 10 BLOCHER ST.

3. NAME OF DECEASED: (Type or Print) (First) ANGELINE (Middle) AMATO (Last)

4. DATE OF DEATH: (Month) 1-26-55 (Day) (Year) 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	WIDOWED	11/17/84	70 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Francisco BENEDUCE Antonio

14. MOTHER'S MAIDEN NAME: Filomena Beneduce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: CHART

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

5927

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic Nephritis —

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/4/55, 19..... to 1/26/55, 19....., that I last saw the deceased alive on 1/25/55 19..... , and that death occurred at 2:15 A M. from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Cumberland DATE SIGNED 1/27/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | **DATE THEREOF** 1-28-55 | **NAME OF CEMETERY OR CREMATORY** S.S. Peter & Paul | **LOCATION** (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1955 | **REGISTRAR'S SIGNATURE** Walter K. Hanby, M.D. | **24. FUNERAL DIRECTOR** Charles L. George | **ADDRESS** Cumberland, Md.

Mr. Lange —

RECEIVED
FEB 2 8 1945
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00002

00001 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 17 days
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, rural
STREET ADDRESS (If rural give location) Rt. #5, Box 242,

3. NAME OF DECEASED: (Type or Print) (First) Jemina (Middle) (redacted) (Last) Anderson
4. DATE OF DEATH: (Month) 1-10-55 (Day) (Year) 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	W	Married	5/30/77	77 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	OwnHome	Allegany County Md.	U.S.A.

13. FATHER'S NAME: Deceased - William Hamilton
14. MOTHER'S MAIDEN NAME: Deceased Martha A. Koontz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No		None	Patient's chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-30, 1954, to 1-10, 1955, that I last saw the deceased alive on 1-10-55, 19..., and that death occurred at 6 40 P. M, from the causes and on the date stated above.

SIGNATURE Roger L. Burris M. D. ADDRESS 62 Greene St Cumberland Md DATE SIGNED 1-11-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 13, '55	Frostburg Mem. Park	Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 11, 1955 — REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer. ADDRESS Cumberland, Maryland

RECEIVED
JAN 19 19[illegible]
BUREAU V. S.

Within corporate limits

Eichorn Funeral Home

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00002 00003

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 1 hr. 15 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moscow X
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) David (Middle) R. (Last) Arnold

4. DATE OF DEATH: (Month) Jan. (Day) 20 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: 10-15-53

9. AGE last birthday [redacted] yrs. / IF UNDER 1 YEAR: Months [redacted] Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Arnold

14. MOTHER'S MAIDEN NAME: Doris Hyde [redacted]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Patients chart.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) dehydration acidosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO gastrointestinal infection — 2 days

(C)

527.2

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20, 1955, to 1/20, 1955, that I last saw the deceased alive on 1/20, 1955, and that death occurred at 8:05 P M, from the causes and on the date stated above.

SIGNATURE Elizabeth Bridges M. D. ADDRESS 55 Greene St. DATE SIGNED 1/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan, 23. 1955 | NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | LOCATION (City, town, or county) (State) Moscow, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1955 | REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, Md.

RECEIVED
FEB 2 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00004

00003

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 2 Weeks
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Water Station Run

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Arnold

4. DATE OF DEATH: (Month) Jan, (Day) 9th (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: June 17th 1890
9. AGE last birthday 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if Pipefitter
10B. KIND OF BUSINESS OR INDUSTRY: Celanese
11. BIRTHPLACE (State or foreign country): Lonaconing
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Arnold
14. MOTHER'S MAIDEN NAME: Elsie Ritchie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes-World War #1
16. SOCIAL SECURITY NO. 220-10-7976
17. INFORMANT & ADDRESS: Mrs. Lawrence Coburn (Sister) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 4 3 X

IMMEDIATE CAUSE (A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Hypertensive Vascular Desease — 2 yrs

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1953, to 9 Jan, 1955 that I last saw the deceased alive on 9 Jan 1955, and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE George Richard Dr. M. D. ADDRESS Lonaconing DATE SIGNED 1/10/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Jan, 12, 1955
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) (State) Lonaconing, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1955
REGISTRAR'S SIGNATURE Walter R. Sauter, M.D.
24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 19 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00005

CERTIFICATE OF DEATH

00060 Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS CO

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg X
STREET ADDRESS (If rural give location) Rt. 2

3. NAME OF DECEASED: (Type or Print) (First) Hoy (Middle) Clifton (Last) Arnold

4. DATE OF DEATH: (Month) Jan. (Day) 15th, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 16th, 1887

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman

10B. KIND OF BUSINESS OR INDUSTRY: Pot. Edison Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Arnold

14. MOTHER'S MAIDEN NAME: Lillian Atkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W. 1

16. SOCIAL SECURITY NO. 220-07-6778

17. INFORMANT & ADDRESS: Mrs. Hoy Arnold, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Coronary heart disease — 3 years.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10, 1955 to 1-15, 1955, that I last saw the deceased alive on 1-15, 1955, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

SIGNATURE W. C. Diehl M.D. ADDRESS Frostburg, Md. DATE SIGNED 1/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 1-18-1955

NAME OF CEMETERY OR CREMATORY Frbg. Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 1-18-55

REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

RECEIVED
JAN 31 1955
BUREAU V. S.

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Dr. Leo Ley

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00006

00004

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 08 815 Braddock Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Maryland 07
STREET ADDRESS (If rural give location) 815 Braddock Road

3. NAME OF DECEASED: (Type or Print) (First) LISTON (Middle) ROY (Last) ASH

4. DATE OF DEATH: (Month) Jan. (Day) 1 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Sept. 20, 1867	87 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Salesman	Great American Tea Co.	Flintstone, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Ash	Amanda Lashley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	220-10-4653	Mrs. Flora Blackwell, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X IMMEDIATE CAUSE (A) Cerebral Sclerosis

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to 1/1, 1955, that I last saw the deceased alive on 12/31, 1954, and that death occurred at 6 P M, from the causes and on the date stated above.

SIGNATURE Leo Ley Jr. M. D. ADDRESS 41 E. Centre St. DATE SIGNED 1/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 4, 1955	I.O.O.F. Cemetery	Flintstone, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 4, 1955	Walter R. Frantz M.D.	John J. Hafer, Cumberland, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00007

00061 **CERTIFICATE OF DEATH** Reg. Dist. No. 9

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

COUNTY: Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg 22

MARYLAND LENGTH OF STAY (in this place): 3yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 84 Frost Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MD. COUNTY: Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg 22

STREET ADDRESS (If rural give location): 84 Frost Ave.

3. NAME OF DECEASED: (Type or Print) First: Elizabeth Middle: Atkinson Last:

4. DATE OF DEATH: (Month) Jan, (Day) 19 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: July 14, 1882

9. AGE last birthday: 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Bell

14. MOTHER'S MAIDEN NAME: Margaret McMillian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Miss. Marion Bell (Sister) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 422.1

(A) DUE TO: arterio-sclerotic cardio-

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) DUE TO: vascular disease.

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1, 1954 to 1-19, 1955, that I last saw the deceased alive on 1-19, 1955, and that death occurred at 2:30 M, from the causes and on the date stated above.

SIGNATURE [illegible] M D ADDRESS [illegible] DATE SIGNED 1/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Jan, 21. 1955

NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-21-55

REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS: George Eishhorn, Lonaconing, Md.

Within corporate limits

00005

00008 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 418 Goethe St.

3. NAME OF DECEASED: (Type or Print) (First) William Wesley (Middle) (Last) Baum

4. DATE OF DEATH (Month) Jan. (Day) 13 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	June 15-1883	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Grocery	Salesburg, Pa.	U.S.A.

13. FATHER'S NAME: W.W.Baum

14. MOTHER'S MAIDEN NAME: Mary Heberlein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	220-16-6887	(wife) Mrs. W.W.Daum, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	about 1/2 hr
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan.13-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 16, 1955	Fillers Burial Park	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 14, 1955	Winter R. Frantz, M.D.	William A. Light	Cumberland, Maryland

Within corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00009

00006 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 9 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 218 Pennsylvania Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland, Md.
STREET ADDRESS (If rural give location) Mexico Farms, R. F. D. #4

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Cora Viola Bloss

4. DATE OF DEATH: (Month) I- (Day) 20- (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Sept 4 1892

9. AGE last birthday 62 yrs. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY. Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathanial Rice

14. MOTHER'S MAIDEN NAME: Anna R. Bradour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Claude R. Bloss Rt. #4 Mexico Farms

18. MEDICAL CERTIFICATION Near Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage 6 hrs.

ANTECEDENT CAUSE (S) (B) DUE TO —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertension —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20/55, 19.., to 1/20/55 19.., that I last saw the deceased alive on 1/20/55 19...., and that death occurred at 8:55 P M. from the causes and on the date stated above.

SIGNATURE O. R. Mullenax M. D. ADDRESS Cumberland DATE SIGNED 1/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF I-23-55

NAME OF CEMETERY OR CREMATORY German Beneficial Cem.

LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

Exhibit

EXHIBIT V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00007

CERTIFICATE OF DEATH

Reg. Dist. No. 00010 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 6/28/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) Gertrude (Last) Bowden

4. DATE OF DEATH: (Month) (Day) (Year) January 30, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 12/21/1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Harrisburg, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Manley

14. MOTHER'S MAIDEN NAME: Caroline Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) Pulmonary Hypostasis — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Cerebral Hemorrhage — 4 years

DUE TO (C) General arteriosclerosis — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension — ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28 1952 to Jan. 27, 1955; that I last saw the deceased alive on Jan. 27, 1955, and that death occurred at 5-9. M, from the causes and on the date stated above.

SIGNATURE James B. Frean M.D. ADDRESS 49 Greene St. DATE SIGNED 1-31-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 2/1/55

NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park

LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR: Jan. 31, 1955

REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: George Eichhorn, Lonaconing, Maryland

RECEIVED
FEB 7 1955
BUREAU V. S.

00008

00011 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland
LENGTH OF STAY (In this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lying along B&O.R.Ry. tracks back of Silk Mill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland 02 1
STREET ADDRESS (If rural, give location) 942 Cay St.

3. NAME OF DECEASED: (Type or Print) (First) Edgar (Middle) Warfield (Last) Bridges
4. DATE OF DEATH (Month) Jan. (Day) 21 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widower	Feb.20-1896	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Shop laborer	Bolt & Forge, B&O R.Ry	Chancysville, Pa.	U.S.A.

13. FATHER'S NAME: William Bridges
14. MOTHER'S MAIDEN NAME: Margaret Bartholow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	705-09-3523	(daughter) Hettie Gray, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial failure	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Chronic myocarditis also had	?
	DUE TO (c) Coronary sclerosis	?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒*

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒*, Inquiry ☐*, and find that death resulted from: Natural causes ☒*, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan.21-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Jan 24 1955	Jan 24 1955	Rose Hill Cemetery	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 24 1955	Hunter R Trout, MD	John J Hafer, Cumberland Md	

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 . 00012

00071 CERTIFICATE OF DEATH Reg. Dist. No. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location) Railroad Street

3. NAME OF DECEASED: (Type or Print) (First) Patrick (Middle) (Last) Cavanaugh

4. DATE OF DEATH: (Month) Jan, (Day) 5th (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH. OCT, 30th. 1869

9. AGE Last birthday 85 yrs IF UNDER 1 YEAR Months IF UNDER 24 HRS Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor

10B. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country) Barton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Cavanaugh

14. MOTHER'S MAIDEN NAME: Margaret Cullan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-20-5382

17. INFORMANT & ADDRESS. Patrick Cavanaugh, Midland, Md. (SON)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 30 sec

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Aortic Aneurysm — 4 years

DUE TO (C) Arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 1952

19B. MAJOR FINDINGS OF OPERATION: Aortic Aneurysm causing Obstruction & Distortion

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1954 to Jan 5, 1955 that I last saw the deceased alive on Jan 5, 1955, and that death occurred at 10 1/4 PM, from the causes and on the date stated above.

SIGNATURE George Eichhorn M.D. ADDRESS Lonaconing DATE SIGNED 1/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan, 8, 1955 — NAME OF CEMETERY OR CREMATORY Belvedere Cemetery — LOCATION (City, town, or county) Midland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-7-55 — REGISTRAR'S SIGNATURE Jeanette M Boal

24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md ADDRESS

Write in space to the right

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00013

00009

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 5 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Penn — COUNTY Cambria
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Johnstown
STREET ADDRESS (If rural give location) 271 Cooper Ave.

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) S. (Last) Colbert

4. DATE OF DEATH: (Month) Jan. (Day) 3 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Aug. 15, 1879

9. AGE last birthday: 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee

10B. KIND OF BUSINESS OR INDUSTRY: City Water Co

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Colbert

14. MOTHER'S MAIDEN NAME: Nancy Hess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 172-03-1949

17. INFORMANT & ADDRESS: Patient's Chart - informant Daughter.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive Cardio Vascular Disease DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 30, 1954 to Jan 3, 1955, that I last saw the deceased alive on Jan 3, 1955, and that death occurred at 12:17 PM, from the causes and on the date stated above.

SIGNATURE Overton Hemmeter Wright M.D — ADDRESS 133 Virginia Ave Cumberland, Md — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial — DATE THEREOF 1/6/55 — NAME OF CEMETERY OR CREMATORY Grandview Cemetery — LOCATION (City, town, or county) Johnstown — (State) Pa.

DATE REC'D BY LOCAL REGISTRAR Jan. 3, 1955 — REGISTRAR'S SIGNATURE Winter L. Hauty, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc — ADDRESS Cumberland, Md

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00014

00010

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
   - COUNTY: Allegany
   - CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
   - MARYLAND — LENGTH OF STAY (in this place): 2days
   - HOSPITAL OR INSTITUTION OR STREET ADDRESS: 12 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   - STATE: MD. — COUNTY: Allegany
   - CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
   - STREET ADDRESS (If rural give location): Church Street X 1

3. NAME OF DECEASED: (Type or Print) (First) Baby Boy (Middle) (Last) Crawford

4. DATE OF DEATH: (Month) Jan, (Day) 16 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Child

8. DATE OF BIRTH: Jan, 14th 1955

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS: yrs. | Months | Days: 2 | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Sherman Crawford

14. MOTHER'S MAIDEN NAME: Margaret Jane Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT & ADDRESS: Sherman Crawford, Lonaconing, Md. (FATHER)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
7760 IMMEDIATE CAUSE	(A) Failure to establish Respiration	2d.
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	(B) Prematurity (6 months) DUE TO	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Jan, 1955, to 16 Jan, 1955, that I last saw the deceased alive on 16 Jan, 1955, and that death occurred at 3 20 A M, from the causes and on the date stated above.

SIGNATURE AND TITLE OF M.D.: [signature] M.D. — ADDRESS: Lonaconing — DATE SIGNED: 1/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Jan, 17 1955 — NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery — LOCATION (City, town, or county) (State): Moscow, MD.

DATE REC'D BY LOCAL REGISTRAR: Jan. 17, 1955 — REGISTRAR'S SIGNATURE: Walter R. Faust, M.D.

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.

2015.11.5281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00015

Item 1, Fil. #177 2-21-55 ot

00062

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
01 COUNTY Allegany
22 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
MARYLAND LENGTH OF STAY (in this place) 2 wks.
61 HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany 01
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 22
STREET ADDRESS (If rural give location) 93 W. Main St., 1

3. NAME OF DECEASED (Type or Print): (First) MAURICE (Middle) BOND (Last) CRAZE

4. DATE OF DEATH: (Month) Jan. (Day) 1, (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: 6-3-1881

9. AGE last birthday: W/ 73 yrs | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired clerk

10B. KIND OF BUSINESS OR INDUSTRY: confectionery store

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. H. Craze

14. MOTHER'S MAIDEN NAME: Mary Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-07-6115A

17. INFORMANT & ADDRESS: Harry Craze, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension with Nephritis — —

DUE TO (C) Uremia — —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. — —

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-, 1954 to 1-1, 1955, that I last saw the deceased alive on 1-1, 1955, and that death occurred at 11:55 A. M, from the causes and on the date stated above.

SIGNATURE H. C. Dick, M. D. ADDRESS Frostburg, Md. DATE SIGNED 1/3/55.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 1-3-1955

NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-3-55

REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00016

00011 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND LENGTH OF STAY (in this place) 8yr.11mos. 22days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Ketreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) State Street

3. NAME OF DECEASED: (Type or Print) (First) Taylor (Middle) S. (Last) Cutter

4. DATE OF DEATH: (Month) 1 (Day) 22 (Year) 1955

5. SEX: m

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: Nov, 27. 1911

9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Cutter

14. MOTHER'S MAIDEN NAME: Jennie McMurdo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Walter Cutter, Lonaconing, md. (Brother)

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: IMMEDIATE CAUSE (A)	Pulmonary Hypostasis	36hrs.
ANTECEDENT CAUSE (B) DUE TO	Chronic Myocarditis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO	Chronic Nephritis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Mental Deficiency.	9yrs.

19A. DATE OF OPERATION:

19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1952, to Jan 21, 1955, that I last saw the deceased alive on Jan 21, 1955 and that death occurred at 11:5a M. from the causes and on the date stated above.

SIGNATURE James E. McLean M.D. ADDRESS 490 Green St DATE SIGNED 1-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan, 24. 1955 | NAME OF CEMETERY OR CREMATORY Old Coney Cemetery. | LOCATION (City, town, or county) (State) Lonaconing, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1955 | REGISTRAR'S SIGNATURE Walter R. Frantz M.D.

24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU P. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00017

DR. VAN ORMER 00012

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH.
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 02
STREET ADDRESS (If rural give location) 108 CLAYBORNE STREET 1

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) R (Last) DARR

4. DATE OF DEATH: (Month) JANUARY (Day) 26 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: DECEMBER 1, 1883

9. AGE last birthday 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: Railroad Car Repairman

11. BIRTHPLACE (State or foreign country): GREEN SPRING, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN P. DARR

14. MOTHER'S MAIDEN NAME: MARY F. CLEM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-10-7998

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) hypertensive vascular disease. ???
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Jan., 1955, to 26 Jan., 1955 that I last saw the deceased alive on 25 Jan., 1955, and that death occurred at 6:05A M, from the causes and on the date stated above.

SIGNATURE W. Alfred V.C. Elmer M.D. ADDRESS 531 Louisiana Ave., Cumberland, Md. DATE SIGNED 1/27/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan 28, 1955 — NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery — LOCATION (City, town, or county) (State) Green Spring W. Va.

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1955 — REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR John F. Hafer — ADDRESS Cumberland, Md.

FEB
BUREAU V

00013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00018

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS 203 Mary Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.
STREET ADDRESS (If rural give location) 203 Mary Street

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) E. (Last) Dean

4. DATE OF DEATH: (Month) I-10- (Day) 55 (Year) 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH. May 10, 1867

9. AGE last birthday 87 yrs. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY. Ownhome

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bucy

14. MOTHER'S MAIDEN NAME: Mary L. Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: R.W. Hamilton 203 Mary St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

ANTECEDENT CAUSE (S) DUE TO (B) Chronic Myocarditis — 3 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: **19B. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)** **21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)**

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. **21E. INJURY OCCURRED While at work ☐ Not while at work ☐** **21F. HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Sept. , 1954 to Jan. 10 , 1955 that I last saw the deceased alive on Jan. 8 , 1955 and that death occurred at 9 P M, from the causes and on the date stated above.

SIGNATURE AND M.D. Clay E. Jarrett — ADDRESS Cumberland — DATE SIGNED 1/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — **DATE THEREOF** I-13-55 — **NAME OF CEMETERY OR CREMATORY** Rose Hill Cem. — **LOCATION (City, town, or county) (State)** Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1955 — **REGISTRAR'S SIGNATURE** Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR AND ADDRESS James F. Scarpelli Cumberland, Md

Within corporate limits DR. R.J.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00019

00014

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MD.
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNA. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EVERETT
STREET ADDRESS (If rural give location) 128 SOUTH STREET

3. NAME OF DECEASED: (Type or Print) (First) AMOS (Middle) CARL (Last) DECKER

4. DATE OF DEATH: (Month) JAN. (Day) 3 (Year) 1955

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED
8. DATE OF BIRTH: SEPT. 21, 1884
9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co-farmer - Everett Milk
10B. KIND OF BUSINESS OR INDUSTRY: Ice Cream Co.
11. BIRTHPLACE (State or foreign country): PASHLEY, PENNA.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ALBERT H. DECKER
14. MOTHER'S MAIDEN NAME: CATHERINE FISHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 178-28-8447
17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	Cerebral Hemorrhage	4 hrs.
ANTECEDENT CAUSE (S) DUE TO (B)	Chronic Myocarditis	—
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	and Arteriosclerosis	—
260 X)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	Diabetes Mellitus Degenerative arthritis of lumbar	

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 12/24/54, 19.., to 1/3/55, 19...., that I last saw the deceased alive on 1/3/55, 19...., and that death occurred at 9:43A M. from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Cumberland DATE SIGNED 1/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Jan. 6, 1955
NAME OF CEMETERY OR CREMATORY Everett Cemetery
LOCATION (City, town, or county) (State) Everett, Pennsylvania

DATE REC'D BY LOCAL REGISTRAR Jan. 3, 1955
REGISTRAR'S SIGNATURE Walter R. Beauty M.D.
24. FUNERAL DIRECTOR Lynford V. Conner
ADDRESS Everett, Penna.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00020

00072

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2yr.5mo.4da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat Furnace ST.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Rural
STREET ADDRESS (If rural give location) R.F.D.2

3. NAME OF DECEASED: (Type or Print) (First) Wilbert (Middle) Asbury (Last) DEREMER

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W.

8. DATE OF BIRTH: 8 29 1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired Bridgeman

10b. KIND OF BUSINESS OR INDUSTRY: W. M. R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Randolph Deremer

14. MOTHER'S MAIDEN NAME: Sarah Jane Starkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Wm. Deremer, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 7 days.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Cerebral Arterio sclerosis — ?

DUE TO (c) Chronic Myocardial Degeneration — ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis — 3 yrs.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 27, 1952 to Jan. 31, 1955, that I last saw the deceased alive on Jan. 31, 1955, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) James B. Frantz M.D. ADDRESS 49 Greene St. DATE SIGNED 2-1-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Feb. 3, 1955 | NAME OF CEMETERY OR CREMATORY Davis Memorial Park | LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 2, 1955 | REGISTRAR'S SIGNATURE Walter K. Frantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS Wm. H. Kight, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1955
BUREAU

00073 00021

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Found dead lying in creek bed near his home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (rural) Cumberland
STREET ADDRESS (If rural, give location) R.F.D.#3 Bowmans Addition.

3. NAME OF DECEASED: (Type or Print) (First) Leonidas (Middle) (Last) Dicken

4. DATE OF DEATH (Month) Jan. (Day) 25 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Widower	Feb. 3-1870	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Salesman	Singer Sewing Machine Co	Warfordsburg, Pa.	U.S.A.

13. FATHER'S NAME: William Dicken

14. MOTHER'S MAIDEN NAME: Rebecca Ann Robinett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		Cumberland, Md. (Son) Presley Dicken, R.F.D.#3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exposure — ?

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
	Creek bed near home,	near Cumberland, Allegany, Maryland.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
1-24-55 11:15 P.M.		Confused in dark, fell in Creek

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Jan. 25-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 27, 1955	Rose Memorial Burial Park	near Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 26, 1955	Winter L. Gauby, M.D.	William A. Light	" "

VS. A15A - 5 - 53

Special query regarding the "Exposure" sent to Doctor --
"Death was caused solely by effects of Exposure"
2/8/55 ams

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00015 **CERTIFICATE OF DEATH** Reg. Dist. No. 00022

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 86 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 402 N. Center St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 402 N. Centre St.

3. NAME OF DECEASED: (Type or Print) (First) Minnie (Middle) L (Last) Diebold

4. DATE OF DEATH (Month) January (Day) 29 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 6, 1861

9. AGE last birthday 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Wales

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Da vid Lewis

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Hazel Schultz 402 N. Centre St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 422.2 (A) Uraemia — 3 wks

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic Myocarditis — 2 yrs.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1955 to Jan. 29, 1955, that I last saw the deceased alive on Jan 26, 1955, and that death occurred at 4 p. M. from the causes and on the date stated above.

SIGNATURE Clay E. Sowers M. D. ADDRESS Cumberland DATE SIGNED 1/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/1/55 — NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery — LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 1, 1955 — REGISTRAR'S SIGNATURE Winter R. Sauk, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

RECEIVED
FEB 7 1955
BUREAU V.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00023

00016

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Cumberland
LENGTH OF STAY (in this place) 7/24/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 22
STREET ADDRESS (If rural give location) 143 Spring Street

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Estella (Last) Dixon

4. DATE OF DEATH: (Month) (Day) (Year) January 18, 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 9/11/1870
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Westernport, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Phillips
14. MOTHER'S MAIDEN NAME: Mary Catherine Hixenbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.2 IMMEDIATE CAUSE	(A) Pulmonary Hypostasis	72 hrs.
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Chronic Myocarditis	?
	DUE TO (C) Chronic Osteo arthritis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic Nephritis	?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1954, to Jan. 18, 1955, that I last saw the deceased alive on Jan. 18, 1955 and that death occurred at 3:10 P.M., from the causes and on the date stated above.
SIGNATURE James E. McLean M. D. ADDRESS 49 Grence St. DATE SIGNED 1-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-21-55
NAME OF CEMETERY OR CREMATORY Tasker Cemetery
LOCATION (City, town, or county) (State) Cross, West Virginia

DATE REC'D BY LOCAL REGISTRAR Jan. 18, 1955
REGISTRAR'S SIGNATURE Walter K. Brady, M.D.
24. FUNERAL DIRECTOR W. A. Fredlock, Piedmont, West Virginia ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00024

00017

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Items 1, 10b, 10c; file 9176 1-24-55 L

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 3 mo. 10days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital
(If not in hospital or institution, give street address or location) Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) J. (Last) Dorsey

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 7, 1955

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: June 1, 1877

9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired, housewife, etc.) Retired Typesetter

10b. KIND OF BUSINESS OR INDUSTRY Factory Elec Co

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Dorsey

14. MOTHER'S MAIDEN NAME: Margaret Cullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-01-3678

17. INFORMANT & ADDRESS: Patient's Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Congestive Cardiac Failure — 6 weeks

DUE TO (C) Arteriosclerotic Cardiac degeneration — 6 mo.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Bronchial asthma

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1954, to Jan. 7, 1955, that I last saw the deceased alive on Jan. 2, 1955, and that death occurred at 5:12 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan, 10, 1955

NAME OF CEMETERY OR CREMATORY Belvedere Cemetery

LOCATION (City, town, or county) (State) Midland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1955

REGISTRAR'S SIGNATURE Wenter R. Wantz, M.D.

24. FUNERAL DIRECTOR George Eichhorn, ADDRESS Lonaconing, Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-57

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00074 00025 Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Lonaconing
LENGTH OF STAY (in this place) 87
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing X
STREET ADDRESS (If rural give location) Railroad Street

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) (Last) Ferrens

4. DATE OF DEATH: (Month) Jan, (Day) 21. (Year) 1955

5. SEX Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed 8. DATE OF BIRTH: Oct 13 1867 9. AGE last birthday 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework 10B KIND OF BUSINESS OR INDUSTRY. Own Home

11. BIRTHPLACE (State or foreign country). Lonaconing, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Archibald Hutchenson

14. MOTHER'S MAIDEN NAME: Marion Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
232X IMMEDIATE CAUSE	(A) Cerebral Thrombosis	3d.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerosis - Generalized	4-5 yrs
	DUE TO (C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 54 to 21 Jan, 1955, that I last saw the deceased alive on 21 Jan, 19 55, and that death occurred at 10 30 A.M., from the causes and on the date stated above.

SIGNATURE Geo. E. Richards Jr. M. D. ADDRESS Lonaconing Md DATE SIGNED 1/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Jan 24. 1955 NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery LOCATION (City, town, or county) Moscow, MD. (State)

DATE REC'D BY LOCAL REGISTRAR 1-24-55 REGISTRAR'S SIGNATURE Jeanette M Boal

24. FUNERAL DIRECTOR George Eichhorn, ADDRESS Lonaconing, Md

Within corporate limits

00018

00026 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (in this place) 3 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS 711 Fairmont Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Va. COUNTY Rockingham

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Harrisonburg

STREET ADDRESS (If rural, give location) 317 Park Place.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Joseph (Last) Fleckenstein

4. DATE OF DEATH (Month) Jan. (Day) 1 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Nov. 25-1906	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Supervisor Mechanical Dept.	Celanese Corp.	Cumberland, Md.	U.S.A.

13. FATHER'S NAME: Sebastian Fleckenstein

14. MOTHER'S MAIDEN NAME: Louise B. Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	214-07-5743	Cumberland, Md. (brother) Vincent G. Fleckenstein

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Myocardial infarction	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Coronary insufficency also had	?
	(c) DUE TO (bilateral) Hydrothorax & ascities.	?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H. V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D.

DATE SIGNED Jan. 5-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 7 1955	St. Peter and Paul Cem	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 6, 1955	Winter R. Frantz, M.D.	Charles L. George, Cumberland, "	

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00027

00019

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 1½ days
42 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS 123 Polk St. (If rural give location) 07 1

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) A. (Last) Fletchinger

4. DATE OF DEATH: (Month) Jan. (Day) 7, (Year) 19 55

5. SEX Female

6. COLOR OR RACE. White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH. 10/20/95

9. AGE last birthday 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office work

10B KIND OF BUSINESS OR INDUSTRY: Dry Cleaning

11. BIRTHPLACE (State or foreign country). Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: George Fletchinger

14. MOTHER'S MAIDEN NAME. May Christi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO 214-05-7104

17 INFORMANT & ADDRESS: Patient's chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 hrs

ANTECEDENT CAUSE (B) DUE TO Acute Pneumonia — 12 hrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Hypostasis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1955 to Jan 7, 1955, that I last saw the deceased alive on Jan 6, 1955, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

SIGNATURE F. Alan L. Murray M.D. ADDRESS Cumberland Md. DATE SIGNED Jan 7/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 1/10/55

NAME OF CEMETERY OR CREMATORY St. Peter & Paul

LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 8, 1955

REGISTRAR'S SIGNATURE Walter L. Trautz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

RECEIVED
JAN 12 1
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00028

00020 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 1 hr
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
STREET ADDRESS (If rural give location) 452 Pine Ave.

3. NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) Lewis (Last) Frazier

4. DATE OF DEATH: (Month) January (Day) 9 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH Sept. 29, 1880

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 74 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10B. KIND OF BUSINESS OR INDUSTRY: Fired Furnaces

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Frazier

14. MOTHER'S MAIDEN NAME: Jane Colley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 72-454-634

17. INFORMANT & ADDRESS: Sacred Heart Hospital Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181x

IMMEDIATE CAUSE (A) DUE TO Cancer primary bladder — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1954 to Jan 9, 1955 that I last saw the deceased alive on Jan 7, 1955, and that death occurred at 4 30 A M, from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, M.D. ADDRESS Cumberland, Maryland DATE SIGNED 1/9/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/12/55 | NAME OF CEMETERY OR CREMATORY Sunset Cemetery | LOCATION (City, town, or county) (State) Cumberland Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1955 | REGISTRAR'S SIGNATURE Wintes K. Lantz, M.D. | 24. FUNERAL DIRECTOR Louis Stein Jr. | ADDRESS Cumberland, Md.

MARYLAND 00021

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

00029

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 813 Lafayette Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural, give location) 813 Lafayette Ave

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) (Last) Furlow

4. DATE OF DEATH (Month) (Day) (Year): January 4 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 22, 1879

9. AGE last birthday: 75 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Flintstone, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Elisha Furlow

14. MOTHER'S MAIDEN NAME: Elizabeth Pennell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Miss Sarah Bucy. Cumberland. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac decompensation (pulmonary edema) due to — 36 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Dis. — 2-3 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 29, 1954 to Jan 4, 1955, that I last saw the deceased alive on Jan 3, 1955 and that death occurred at 6 45 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. J. Mirkin M.D. ADDRESS Cumberland, Md DATE SIGNED 1-4-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE January 6, 1955 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Jan. 5, 1955 — REGISTRAR'S SIGNATURE: Walter R. Trautz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Md.

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00022

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH. COUNTY: Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland, Maryland
LENGTH OF STAY (in this place):
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR: Cumberland, Maryland
STREET ADDRESS (If rural give location): Route #1, Alleghany Grove, Cumberla

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) May (Last) Gerbing

4. DATE OF DEATH: January (Month) 1, 1955 (Day) (Year) 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 27, 1882
9. AGE last birthday: 72 yrs. yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Dry
10B. KIND OF BUSINESS OR INDUSTRY: Foster's Dye Wks
11. BIRTHPLACE (State or foreign country): Pennsylvania - Johnstown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Day (Cleaning Employee)
14. MOTHER'S MAIDEN NAME: Margaret Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.): No
(If Yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Mrs. Jesse Kare. Rt. 1. Cumberland Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) cardiac decompensation	1 yr.
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) pulmonary fibrosis DUE TO	5 yrs.
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1945, to 1/1 ....., 1955, that I last saw the deceased alive on 1/1 ....., 1955, and that death occurred at 8:35P M, from the causes and on the date stated above.
SIGNATURE: Elizabeth Grimes M.D. ADDRESS: 55 Greene St. Cumberland, Md. DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Jan. 4 1955
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 3, 1955
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR: John J. Hafer
ADDRESS: Cumberland Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 19[illegible]
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00031

CERTIFICATE OF DEATH

00063 Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miller's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Borden Mines
STREET ADDRESS (If rural give location) Frostburg

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Henry (Last) Gordon
4. DATE OF DEATH (Month) 1 (Day) 26 (Year) 1955
5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 26 1879
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Miner
10B. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): Borden Mines, Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Wm. T. Gordon
14. MOTHER'S MAIDEN NAME: Barbara Bennett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Corriganville, Md. Benjamin E. Gordon

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

177X IMMEDIATE CAUSE (A) Carcinoma Prostate — 6 mo

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 14, 1955, to Jan 26, 1955, that I last saw the deceased alive on Jan 23, 1955, and that death occurred at 5:30 A M, from the causes and on the date stated above.

SIGNATURE W. M. Lane M. D. ADDRESS Frostburg Md DATE SIGNED 1-29-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1-28-1955 NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-28-55 REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe 24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00064

00C32
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 22 Frostburg

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 97 Dead on arrival at the Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Savage X

STREET ADDRESS (If rural, give location) Old Row

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Samuel	Grady	Jan.	15	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	Married	Oct. 31-1915	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Truck Driver-	Hazelwood Construction Co.	Mt. Savage, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Charles Grady	Lillian Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	220-10-2323	(wife) Sarah Beeman Grady, Mt Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary occlusion	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Coronary sclerosis (angina syndrome)	?
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M. D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan. 16-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-19-55	St Patrick	Mt Savage	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-18-55	Mrs Nancy N. Roe	Harvey H. Zeigler	Frostburg, Md.

Within Corporate limits

Dr. R.J. Wms.

00023

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00033

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 2 days
60 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 1 102 Virginia Avenue

3. NAME OF DECEASED: (Type or Print) (First) Clara (Middle) E (Last) Grimm

4. DATE OF DEATH: (Month) Jan. (Day) 7 (Year) 19 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: October 22, 1885

9. AGE last birthday IF UNDER 1 YEAR / IF UNDER 24 HRS. 69 yrs. | Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country): Rowlesburg, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zacharia Felton

14. MOTHER'S MAIDEN NAME: Mary Jane Tanner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Virus pneumonia left lung — 7 days

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/5/55, 19.., to 1/7/55, 19 , that I last saw the deceased alive on 1/7/55, 19 ., and that death occurred at 6 05 M., from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Cumberland DATE SIGNED 1/7/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: I-10-55

NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 9, 1955

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS Cumberland, Md.

Outside of City Limits

Dr. Smith Will 00075

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 7 00034

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 5, Roberts' Place

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural give location) R.D. # 6 Potomac Park

3. NAME OF DECEASED: (First) Cornelius (Middle) Earl (Last) Grindle

4. DATE OF DEATH: (Month) Jan. (Day) 7, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 7-28-1903

9. AGE last birthday 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10B. KIND OF BUSINESS OR INDUSTRY: Rubber Co.

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Grindle

14. MOTHER'S MAIDEN NAME: Linda Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-6126

17. INFORMANT & ADDRESS: Mrs. Violet Grindle R.D 5 Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis DUE TO — INTERVAL BETWEEN ONSET AND DEATH 30 minutes

ANTECEDENT CAUSE (B) Had previous attack 1½ yrs ago DUE TO — —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/2/54, 19....., to 1/7/55, 19....., that I last saw the deceased alive on 1/7/55, 19....., and that death occurred at 2 P.M. from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Cumberland DATE SIGNED 1/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-10-1955 | NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. | LOCATION (City, town, or county) Moscow, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1955 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00035

09076 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 2, Baltimore Pike

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, rural
STREET ADDRESS (If rural give location) Route 2, Baltimore Pike

3. NAME OF DECEASED. (Type or Print) (First) JOHN (Middle) FRANKLIN (Last) GURLEY

4. DATE OF DEATH (Month) January (Day) 24 (Year) 1955

5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married 8. DATE OF BIRTH: Jan. 9, 1872 9. AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret, Farmer 10B. KIND OF BUSINESS OR INDUSTRY: General Farming 11. BIRTHPLACE (State or foreign country): Union Grove, Alleg, Co. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LYCURGUS GURLEY Own Farm

14. MOTHER'S MAIDEN NAME: Md. BELLE FRANTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Rt. 2, Balt. Pike Mrs. Grace Gurley, Cumberland, Mary

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/22, 1955, to 1/24, 1955, that I last saw the deceased alive on 1/22, 1955, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE Jas. H. Levy Jr. M. D. ADDRESS 458 N. Centre St DATE SIGNED 1/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Jan. 26, 1955 NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery LOCATION (City, town, or county) Woodsboro, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 25, 1955 REGISTRAR'S SIGNATURE Walter L. Lantz, M.D. 24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland, Maryland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

FEB 2 19[illegible]

Within corporate limits

MARYLAND 00024

STATE DEPARTMETT OF HEALTH

00036

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
HOSPITAL OR INSTITUTION OR STREET ADDRESS 363 Bedford Street 00
MARYLAND
LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural, give location) 363 Bedford Street 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANNIE	CATHERINE	HAFER	January 6, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs Hours	Min.
Female	White	Widow	Feb. 3, 1871	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Cumberland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY KOHL	CATHERINE SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mr. Newton Parrish, Cumberlan[illegible], Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Heart Failure	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Tumor of Left Kidney	1 year
(c)	Hematuria	6 mos

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 1, 1955, to Jan. 6, 1955, that I last saw the deceased alive on Jan. 5, 1955, and that death occurred at 6:10 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 9, 1955	Greenmount Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 8, 1955	Wintes R. Beatty, M.D.	John J. Hafer,	Cumberland, Maryland

RECEIVED
JAN 12 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00037

00025

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 3 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital Decatur St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Viola (Middle) Jean (Last) Haines

4. DATE OF DEATH: (Month) January (Day) 23 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married | 8. DATE OF BIRTH: Sept 22, 1927 | 9. AGE last birthday: 27 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | 10B. KIND OF BUSINESS OR INDUSTRY: Own Home | 11. BIRTHPLACE (State or foreign country): Braddock, Pa. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McINTOSH | 14. MOTHER'S MAIDEN NAME: Mary McCONNELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS: Vernon Haines, Lonaconing, Md. (HUSBAND)

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
6/12X IMMEDIATE CAUSE	(A) Massive Uterine Hemorrhage	3 d.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (B) Necrosis of Uterus.	3d.
	DUE TO (C) Ery Thoblastotic Dead Fetus	10 d.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to 23 Jan, 1955, that I last saw the deceased alive on 23 Jan, 1955, and that death occurred at 3:30 P M, from the causes and on the date stated above.

SIGNATURE George Eichhorn M.D. | ADDRESS Lonaconing | DATE SIGNED 1/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan, 26, 1955 | NAME OF CEMETERY OR CREMATORY Philos Cemetery | LOCATION (City, town, or county) (State) Westernport, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 25, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR George Eichhorn | ADDRESS Lonaconing, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB
BUREAU W. S.

DR. WEISMAN **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 00038

00026 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (In this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 910 GAY STREET

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) H (Last) Hamill

4. DATE OF DEATH: (Month) JAN (Day) 3 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH. JAN 20. 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Textile Plant

11. BIRTHPLACE (State or foreign country): MARTINSBURG, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE Hamill

14. MOTHER'S MAIDEN NAME: SARAH, Thorpe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-7411

17. INFORMANT & ADDRESS: Harry Shewbridge Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

57 X

IMMEDIATE CAUSE (A) DUE TO carcinoma of Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 1946, to Jan 3, 1955, that I last saw the deceased alive on Jan 2, 1955, and that death occurred at 7:35 AM, from the causes and on the date stated above.

SIGNATURE AND M. D. J. Emerman ADDRESS Cumberland Md DATE SIGNED 1/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF I-5-55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 4, 1955 | REGISTRAR'S SIGNATURE Walter L. Bantz M.D.

24. FUNERAL DIRECTOR AND ADDRESS James F. Scarpelli Cumberland,

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00027

00040

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
01 COUNTY Allegany MARYLAND
02 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 20 hrs.
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany 01
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 221 Pear Street

3. NAME OF DECEASED: (Type or Print) (First) Agnes (Middle) Hannon (Last)

4. DATE OF DEATH (Month) 1-1-55 (Day) (Year) 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2-15-92
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Dailey
14. MOTHER'S MAIDEN NAME: Anna (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) No. If Yes, give war or dates of service.
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Thomas F Hannon (Husband)

18. MEDICAL CERTIFICATION

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE	(A) DUE TO	Hemorrhage from Bowel	24 hrs
ANTECEDENT CAUSE (S)		diabetes	4 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO	Hypertension	
	(C)	Cerebral Hemorrhage with	3 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Reiter Paralysis	3½ mos

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950 to Jan 1, 1955, that I last saw the deceased alive on Jan 1, 1955, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

SIGNATURE F. Wm. G. Murray M.D. ADDRESS 41 Frost Cumberland DATE SIGNED Md

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Jan. 5, 1955
NAME OF CEMETERY OR CREMATORY: St Patrick's Cem
LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REGISTRAR: Jan. 4, 1955
REGISTRAR'S SIGNATURE: Walter R. Krantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc. ADDRESS: Cumb. Md

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00028

CERTIFICATE OF DEATH

00039 4

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 35yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 221 Virginia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 221 Virginia Ave.

3. NAME OF DECEASED: (Type or Print) (First) Sam (Middle) N. (Last) Harris

4. DATE OF DEATH: (Month) I-30-55 (Day) (Year) 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Dec. 15, 1895

9. AGE last birthday: 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker

10B. KIND OF BUSINESS OR INDUSTRY: Candy Kitchen

11. BIRTHPLACE (State or foreign country) Sparta, Greece

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Harris (own)

14. MOTHER'S MAIDEN NAME: Nicholata — Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) War I

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Lena Harris 221 Virginia Ave.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Coronary Thrombosis	Immediate
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Coronary arteriosclerosis	5yrs
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/14/52, 19..., to 1/30/55, 19..., that I last saw the deceased alive on 1/29/55, 19..., and that death occurred at 10:35 P M, from the causes and on the date stated above.

SIGNATURE R. Kullman M. D. ADDRESS Cumberland DATE SIGNED 2/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2-3-55

NAME OF CEMETERY OR CREMATORY Rose Hill Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 1, 1955

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md

FEB 7 1955

BUREAU V. S.

Within corporate limits:

DR. R. J. WMS MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00041

00029

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 316 DAVIDSON STREET

3. NAME OF DECEASED: (Type or Print) (First) MATILDA (Middle) J. (Last) HARTMAN

4. DATE OF DEATH. (Month) JAN. (Day) 17 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: JULY 25 1883

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B KIND OF BUSINESS OR INDUSTRY: OWN HOME

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEVIN TWIGG

14. MOTHER'S MAIDEN NAME: ORLENA NICELY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: W. W. Hartman, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO: Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) DUE TO: Art Sclr C.V.D. —

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Hernia — 6 days

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10/55, 19 , to 1/16/55, 19 , that I last saw the deceased alive on 1/16/55, 19 , and that death occurred at 7:15 A M, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Cumberland Md. DATE SIGNED 1/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Jan. 19, 1955

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberl nd, Maryland

DATE REC'D BY LOCAL REGISTRAR: Jan. 18, 1955

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00042

00077 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, Cumberland
LENGTH OF STAY (in this place) 32 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 3, Bedford Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural give location) Route 3, Bedford Road

3. NAME OF DECEASED: (Type or Print) (First) Lester (Middle) Moler (Last) Hendricks

4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: July 9 1891

9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Post Office

11. BIRTHPLACE (State or foreign country): Keedysville, Washington Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Newton M/ Hendricks

14. MOTHER'S MAIDEN NAME: Md. Kate Moler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W.I

16. SOCIAL SECURITY NO 214-05-9933

17. INFORMANT & ADDRESS: Mrs. Dorothy Hendricks, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X

IMMEDIATE CAUSE (A) Cancer Urinary bladder DUE TO — INTERVAL BETWEEN ONSET AND DEATH 2 yrs 6 mos

ANTECEDENT CAUSE (S) (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 26, 1954 to Jan 7, 1955, that I last saw the deceased alive on Dec 15, 1954, and that death occurred at 12:30 AM, from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, Jr. M.D. ADDRESS Cumberland, Maryland DATE SIGNED 1/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan 10 1955 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

Within corporate limits

00030

00043

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 343 Williams St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Bernard	Higgins	Jan.	4	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	widower	Oct. 10-1889	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Railroad Accountant	B.O.R.Ry.	Harpers Ferry, W.Va.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Michael J.Higgins	Mary A.Bowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
yes W.W.I	705-05-3174	Mrs.Paul Staker, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Coronary sclerosis.	?
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan.5-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan.7,1955	St. Patricks Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 6, 1955	Wister R. Mantz, M.D.	Joseph F. Scarpelli,	" "

RECEIVED
JAN 12 1955
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00078

00044/

Reg. Dist. No. 7

1. PLACE OF DEATH:
COUNTY Allega ny MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural
LENGTH OF STAY (in this place) 20 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 R.F.D. 3 Bedford Rd.

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Rural X
STREET ADDRESS (If rural give location) R.F.D. 3 Bedford Rd. 1

3. NAME OF DECEASED: (Type or Print) (First) Richard (Middle) L.W. (Last) Hoffman

4. DATE OF DEATH: (Month) January (Day) 17 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 10/2/[illegible] 1861

9. AGE last birthday 93 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boiler

10B. KIND OF BUSINESS OR INDUSTRY: Ma ker W.M. Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard Hoffman

14. MOTHER'S MAIDEN NAME: Anna Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Louis Hoffman R.F.D. 3 Bedford Rd.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221

IMMEDIATE CAUSE (A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSE (S) DUE TO Arteriosclerosis — 5 4

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1954 to Jan 17, 1955, that I last saw the deceased alive on Jan 8, 1955, and that death occurred at 130 P M, from the causes and on the date stated above.

SIGNATURE R. W. Trewatskis, Jr. ADDRESS M. D. Cumberland, Md DATE SIGNED 1/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 1/18/55

NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery

LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Jan 18, 1955

REGISTRAR'S SIGNATURE Wirt R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00079

00045

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart Mines

LENGTH OF STAY (in this place): 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Pa COUNTY Bedford

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Saxton

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Charles Monroe Huffman	Jan. 9 19 55	male	white	widower	Feb. 16-1884	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Barber		Huntington, Pa.	U.S.A

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Huffman	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	167-10-3337	(daughter) Mrs Ralph Bowser, Eckhart Mines Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Coronary sclerosis	?
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan. 10-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-12-1955	Odd Fellows Cemetery	Saxton Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-12-55	Mrs. Nancy N. Roe	Jacob Hafer	Frostburg, Md.

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00031

00046 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: rear-630 Lincoln St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Rear- 630 Lincoln St.

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary Helen Huster	Jan. 26 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	White	Widow	July 17-1896	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Cumberland, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Lottig	Lydia Goodwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		(brother) George Lottig, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Coronary sclerosis	?
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☑ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ M. D.
DATE SIGNED: Jan. 26-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 28, 1955	Mt. Lemmon Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 27, 1955	Winter L. Trautz, M. D.	Louis Stein, Inc.,	Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00047

00032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 819 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 819 Bedford St.

3. NAME OF DECEASED: (Type or Print) (First) CARROLL (Middle) HEDGES (Last) JOHNSON

4. DATE OF DEATH: (Month) Jan. (Day) 11 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 8, 1895

9. AGE last birthday: 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert R. Johnson

14. MOTHER'S MAIDEN NAME: Ettie S. Harman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes — (If Yes, give war or dates of service) W. W. 1

16. SOCIAL SECURITY NO. 217-10-4629

17. INFORMANT & ADDRESS: Mrs Ethel Johnson, 819 Bedford St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2
IMMEDIATE CAUSE (A) Chronic Myocardosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan , 1952, to Jan 11 , 1955, that I last saw the deceased alive on Jan 10 , 1955 , and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE John A. Topper M. D. ADDRESS Hyndman Pa DATE SIGNED Jan 11-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Jan. 13, 1955 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 12, 1955 — REGISTRAR'S SIGNATURE: Winter R. Trautz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Charles L. George, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

00065

00048

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg; MARYLAND; LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mares Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg; STREET ADDRESS (If rural, give location) Mares Hospital

3. NAME OF DECEASED (Type or Print): (First) Baby; (Middle); (Last) Jones

4. DATE OF DEATH: (Month) Jan; (Day) 8; (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: Jan 8 55

9. AGE: Last birthday ____ yrs. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours 7 Min. 37

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frbrg Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Norma Jean Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Norma Jean Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity 6 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1955, to Jan 8, 1955, that I last saw the deceased alive on Jan 5, 1955, and that death occurred at 10:00 A m., from the causes and on the date stated above.

SIGNATURE: W M C Lane (Degree or title) MD ADDRESS: Frostburg Md DATE SIGNED: Jan 8 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 1-9-55

NAME OF CEMETERY OR CREMATORY: Johnson's Cemetery

LOCATION (City, town, or county) (State): Star Route #1 Md.

DATE REC'D BY LOCAL REG.: 1-9-55

REGISTRAR'S SIGNATURE: Dan Hauck M.D.

24. FUNERAL DIRECTOR: Jacob Hafer

ADDRESS: Frostburg, Md.

VS. A15

2015174261

RECEIVED
JAN 12 1955
BUREAU V. S.

Write in ink or type

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00049

00033

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
MARYLAND LENGTH OF STAY (in this place) 1 Day
02
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 02
STREET ADDRESS (If rural give location) 110 Bedford STREET

3. NAME OF DECEASED: (Type or Print) (First) MINNIE (Middle) LORETTA (Last) KELLEY

4. DATE OF DEATH: (Month) Jan. (Day) 4 (Year) 19 55

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH: 4-4-85 | 9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B KIND OF BUSINESS OR INDUSTRY: Own Home | 11 BIRTHPLACE (State or foreign country): MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel D Young

14. MOTHER'S MAIDEN NAME: Mary M Canfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT & ADDRESS: Patients chart Sacred Heart Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Acute coronary occlusion	1 day
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	(B) coronary sclerosis DUE TO	1 year
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-3-, 1955, to 1-4-, 1955, that I last saw the deceased alive on 1-4-, 1955, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS 57 Green St. DATE SIGNED 1-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/7/55	St. Peter & Paul	Cumberland Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 6, 1955 | REGISTRAR'S SIGNATURE Walter L. Fraley, M.D. | 24. FUNERAL DIRECTOR Louis Stein, Inc. | ADDRESS Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

DR. SIMONS

00034

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00050

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, Rural
STREET ADDRESS (If rural give location) R.F.D. #1 CUMBERLAND, MD.

3. NAME OF DECEASED: (Type or Print) (First) CHRISTIAN (Middle) HENRY (Last) KRAUS

4. DATE OF DEATH (Month) 1 (Day) 9 (Year) 1955

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: FEB. 13, 1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Clerk RETIRED

10B. KIND OF BUSINESS OR INDUSTRY. B & O Railroad

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GOTLEIB KRAUS

14. MOTHER'S MAIDEN NAME: JULIA SHAFFER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-05-3156

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Generalized arteriosclerosis

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/ 4, 1955, to 1/ 9, 1955, that I last saw the deceased alive on 1/ 9, 1955, and that death occurred at 10:10 A M, from the causes and on the date stated above.

SIGNATURE George M. Brown, M.D. ADDRESS Cumberland Md DATE SIGNED 1/10/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan. 12, '55

NAME OF CEMETERY OR CREMATORY Zion Memorial Park

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 11, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer

ADDRESS Cumberland, Maryland

VS. A15—10-53

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00051

00080

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dawson
LENGTH OF STAY (in this place): X
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route #3

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dawson
STREET ADDRESS (If rural give location): Route #3

3. NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) Jackson (Last) Lancaster

4. DATE OF DEATH: (Month) Jan. (Day) 14, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 26, 1899

9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR: Months 0 Days 18 IF UNDER 24 HRS.: Hour. Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Chemical Process Operator

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp

11. BIRTHPLACE (State or foreign country): Garrett Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Lancaster

14. MOTHER'S MAIDEN NAME: Ruth Waxler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Walter E. Lancaster, Baltimore, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 151X Generalized Carcinomatosis — Interval Between Onset And Death: probably 2 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Carcinoma Stomach and Esophagus — probably 3-4 yrs
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Secondary Anemia — Unknown 6 - 8 mos

19a. DATE OF OPERATION: July 28, 1955

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach, involving esophagus

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1955, to Jan 14, 1955, that I last saw the deceased alive on Jan 14, 1955, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Paul F Healy M.D. — ADDRESS: Potomac Valley Hospital Keyser W Va — DATE SIGNED: Jan 14, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-16-55 — NAME OF CEMETERY OR CREMATORY: Waxler Cemetery — LOCATION (City, town, or county) (State): Allegany Co, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 16, 1955 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Rogers Funeral Home — ADDRESS: Keyser, W.Va.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00035

CERTIFICATE OF DEATH

Reg. Dist. No. 00052 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; LENGTH OF STAY (in this place) 4 hrs 52 min; HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural; STREET ADDRESS (If rural give location) Route #5., Triple Lakes

3. NAME OF DECEASED: (Type or Print) (First) Arlie (Middle) Lease, Sr. (Last)

4. DATE OF DEATH: (Month) 1-4-55 (Day) (Year) 19

5. SEX M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH. Sept 7, 1896

9. AGE last birthday 58 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Dairy Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Reuben T. Lease

14. MOTHER'S MAIDEN NAME Hattie Lease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-1641

17. INFORMANT & ADDRESS Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Apoplectic Stroke — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) DUE TO arterial hypertension — 1 month

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4-1955, to 1-4-1955, that I last saw the deceased alive on 1-4-1955, and that death occurred at 8:45 A M, from the causes and on the date stated above.

SIGNATURE Walter L. Krantz M.D. ADDRESS 5 Thomas St. DATE SIGNED 1-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-6-55 | NAME OF CEMETERY OR CREMATORY Lease Cem. | LOCATION (City, town, or county) (State) Creaptown, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 6, 1955 | REGISTRAR'S SIGNATURE Walter L. Krantz, M.D. | 24. FUNERAL DIRECTOR Charles L. George | ADDRESS Cumb. Md

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00053

00036

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 SACRED HEART HOSPITAL 215 DECATUR STREET

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 121 HANOVER STREET

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) LEYDIG (Last)

4. DATE OF DEATH: (Month) 1-4- (Day) (Year) 19 55

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED

8. DATE OF BIRTH: July 21 1858

9. AGE last birthday: 96 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Somerset County, Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Sumpstin

14. MOTHER'S MAIDEN NAME: Mary Ankny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Harvey Leydig, Somerset, Pa.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 4 Da.

ANTECEDENT CAUSE (B) DUE TO Arteriosclerotic Heart Disease — 15 Yr.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Advanced Age.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1955, to Jan. 4, 1955, that I last saw the deceased alive on Jan. 4, 1955, and that death occurred at 8.05 P.M., from the causes and on the date stated above.

SIGNATURE [illegible] M.D. ADDRESS 140 Bedford St. Cumberland, Md. DATE SIGNED 1-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan 7 1955 — NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery — LOCATION (City, town, or county) (State) Glenco, Somerset Co Pa

DATE REC'D BY LOCAL REGISTRAR Jan. 6, 1955 — REGISTRAR'S SIGNATURE Wister R. Hanby, M.D.

24. FUNERAL DIRECTOR Johnson & Son — ADDRESS Berlin, Pa.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

RECEIVED
JAN 12 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00081 CERTIFICATE OF DEATH

Reg. Dist. No. 00054

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Savage; MARYLAND LENGTH OF STAY (in this place) life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage X; STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) SIMEON (Last) LOGSDON

4. DATE OF DEATH: (Month) Jan. (Day) 27, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) divorced

8. DATE OF BIRTH: 12-7-1907

9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR: Months; IF UNDER 24 HRS.: Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Firemen on railroad

10B. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Logsdon

14. MOTHER'S MAIDEN NAME: Nora Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-07-2702

17. INFORMANT & ADDRESS. Leo A. Logsdon, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cancer Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO /

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1954, to Jan 27, 1955, that I last saw the deceased alive on Jan 27, 1955, and that death occurred at 12 PM, from the causes and on the date stated above.

SIGNATURE John C Logsdon MD M.D. ADDRESS Physician Gr DATE SIGNED Jan 30 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial; DATE THEREOF 1-29-55; NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery; LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 2/2/55; REGISTRAR'S SIGNATURE Veronica McDermott

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00055

00082 **CERTIFICATE OF DEATH** Reg. Dist. No. 14

1. PLACE OF DEATH: 01 COUNTY Allegany — MARYLAND
X CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Corriganville | LENGTH OF STAY (In this place) Life
00 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: 01
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Anne (Middle) (Chowery) (Last) Matthews

4. DATE OF DEATH: (Month) Jan (Day) 3 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed | 8. DATE OF BIRTH: Jan 17, 1872 | 9. AGE Last birthday 82 Yrs | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY Housework | 11. BIRTHPLACE (State or foreign country): Mt. Savage, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lowery | 14. MOTHER'S MAIDEN NAME: Virginia Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S ADDRESS: Albert Matthews, Corriganville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153X IMMEDIATE CAUSE (A) Carcinoma Sigmoid — 2 yrs.

ANTECEDENT CAUSE (S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. , 1953, to Jan 3, 1955, that I last saw the deceased alive on Jan 3, 1955, and that death occurred at 11 30/A M, from the causes and on the date stated above.

SIGNATURE John A Topper M. D. ADDRESS Hyndman Pa DATE SIGNED 1-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan 6, 1955 | NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan 4 1955 | REGISTRAR'S SIGNATURE Floyd Wolfe | 24. FUNERAL DIRECTOR Harvey H. Zeigler | ADDRESS Hyndman Pa.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00056

00083

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH

COUNTY Allegany — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cresaptown

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Route 5, Box 143

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown X

STREET ADDRESS (If rural give location) Route 5, box 143

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
Thomas		McElfish	January 13 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 27, 1904	59 yrs	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pensioner	Celanese Corporation	Rush, Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Irvin G. McElfish	Bertha Hinkle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No		217-10-6542	Mrs. Aileen McElfish, Cresaptown, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE	(A) Cardiac arrest	?
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (B) Hypertensive cardiovascular disease	5 years
	DUE TO (C) Hypertensive vascular disease, aborted ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Mastoiditis, Coalescent	4 years

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Dec. , 19 49 to 13 January, 19 55, that I last saw the deceased (alive on 6 January, 19 55, and that death occurred at 9:15 A.M. from the causes and on the date stated above.

SIGNATURE W. Alfred Van Ormer M.D. ADDRESS 531 Louisiana Ave., Cumberland, Md. DATE SIGNED 1/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 16, 1955	Hillcrest Burial Park	Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 14, 1955	Wouter R. Brantz, M.D.	John J. Hafer, Cumberland, Maryland

within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00037

CERTIFICATE OF DEATH

Reg. Dist. No. 00057 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) Melvin (Middle) F. (Last) McKenzie

4. DATE OF DEATH (Month) (Day) (Year) January 29 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: April 25, 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10B. KIND OF BUSINESS OR INDUSTRY: St Marys Church

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McKenzie

14. MOTHER'S MAIDEN NAME: Harriet Layman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-20-6147

17. INFORMANT & ADDRESS: Wife Emma McKenzie Lonaconing, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Occlusion — 1 hour

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Coronary Heart Disease — 3-4 yrs
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Perforated Gangrenous Appendix — 4 d.

19A. DATE OF OPERATION: 1/24/55

19B. MAJOR FINDINGS OF OPERATION: Perforated Gangrenous Appendix & Peritonitis

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to 1/29/55, 19, that I last saw the deceased alive on 1/29/55, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Lonaconing DATE SIGNED 1/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Feb 1, 1955
NAME OF CEMETERY OR CREMATORY: ST. Marys Cemetery
LOCATION (City, town, or county) (State): Lonaconing, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan 31, 1955
REGISTRAR'S SIGNATURE: Walter L. Krantz, M.D.

24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

RECEIVED
FEB 7 19

DR. W.F.WILLIAMS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00038

CERTIFICATE OF DEATH

00058

Reg. Dist. No. 7

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
MARYLAND LENGTH OF STAY (in this place) 28 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 07
STREET ADDRESS (If rural give location) 605 WASHINGTON ST.

3. NAME OF DECEASED: (Type or Print) (First) FRANK (Middle) C. (Last) MYERS

4. DATE OF DEATH: (Month) JAN. (Day) 10 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED

8. DATE OF BIRTH: APRIL 10, 1881

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR, Months IF UNDER 24 HRS., Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if Supp't. of Loc. Co.

10B. KIND OF BUSINESS OR INDUSTRY: City Ice & Fuel Co., Cumberland

11. BIRTHPLACE (State or foreign country): ECKHART, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL MYERS

14. MOTHER'S MAIDEN NAME: NANCY HARDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-5102

17. INFORMANT & ADDRESS. Mrs. Wm. G. Barkdoll, Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE

(A) Cronic Nephritis (Uremia).

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) C.V. Myocardial Degeneration

DUE TO (C) Coronary Arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Diabetes

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-7-, 1955, to 1-10-, 1955 that I last saw the deceased alive on 1-10-, 1955, and that death occurred at 10:14 A M, from the causes and on the date stated above.

SIGNATURE M.D. ADDRESS Cumberland, Md. DATE SIGNED 1-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan. 12, 1955

NAME OF CEMETERY OR CREMATORY Eckhart Cemetery

LOCATION (City, town, or county) (State) Eckhart Mines, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 11, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland, Maryland

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00059

00039

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY ALLEGANY
02 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 2 days 3 hrs
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 1103 Lexington Ave.

3. NAME OF DECEASED: (Type or Print) (First) Shirley (Middle) Ann (Last) Myers

4. DATE OF DEATH: (Month) (Day) (Year) 1-18-55 19

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single | 8. DATE OF BIRTH. 1-16-55 | 9. AGE last birthday: yrs. | IF UNDER 1 YEAR: Months | Days 2 | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant | 10B. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): Cumberland, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM MEYERS | 14. MOTHER'S MAIDEN NAME: ANNA GROSS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS. William Myers, Cumberland, Md. Mothers chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) DUE TO prematurity, resp'r & cardiac arrest

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/17, 19 55, to 1/18, 19 55, that I last saw the deceased alive on 1/18, 19 55, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Elizabeth Briggs M. D. ADDRESS 55 Greene St. DATE SIGNED 1/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/20/55 | NAME OF CEMETERY OR CREMATORY Abe Cemetery | LOCATION (City, town, or county) (State) Near Pattersons Creek W. Va.

DATE REC'D BY LOCAL REGISTRAR Jan. 20, 1955 | REGISTRAR'S SIGNATURE Walter K. Frantz, M.D. | 24. FUNERAL DIRECTOR John F. Hafer | ADDRESS Cumberland Md

VS. A15—10-53

2015213360

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00060

00084 **CERTIFICATE OF DEATH** Reg. Dist. No. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS East Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing X
STREET ADDRESS (If rural give location) East Main Street 1

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) (Last) Peebles

4. DATE OF DEATH: (Month) (Day) (Year) Jan, 3rd. 1955

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Aug, 12th. 1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Electrician

10B. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country) Lonaconimg, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME. ThomasbPeebles

14. MOTHER'S MAIDEN NAME Mary Fleming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-05-2919

17. INFORMANT & ADDRESS: Robert Peebles, Lonaconing, Md. (SON)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO Hypertensive Vascular Disease — 2 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954 to , 19 55 that I last saw the deceased alive on Jan 3, 1955, and that death occurred at 11:30 AM, from the causes and on the date stated above.

SIGNATURE George E. Eichhorn Jr. M. D. ADDRESS Lonaconing Md DATE SIGNED 1-4-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan, 5, 1955 — NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery. — LOCATION (City, town, or county) (State) Lonaconing, MD.

DATE REC'D BY LOCAL REGISTRAR 1-5-55 — REGISTRAR'S SIGNATURE Jannette M Boal

24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00040 00061

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
21 COUNTY ALLEGANY MARYLAND
02 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY HAMPSHIRE
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) ALONZO (Middle) L. (Last) PETERS

4. DATE OF DEATH: (Month) JANUARY (Day) 26 (Year) 1955

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: FEB. 16, 1878
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10B. KIND OF BUSINESS OR INDUSTRY: CIRCUIT COURT, ROMNEY
11. BIRTHPLACE (State or foreign country): KIRBY, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES PETERS
14. MOTHER'S MAIDEN NAME: Lollie Hott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 236-50-0002
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH about 13 hrs.

ANTECEDENT CAUSE (B) DUE TO Generalized Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-26, 1955, to 1-26, 1955, that I last saw the deceased alive on 1-26, 1955, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

SIGNATURE W.F. Williams M.D. ADDRESS Cumberland DATE SIGNED 1-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Jan 29 1955
NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery
LOCATION (City, town, or county) (State) Romney, Hampshire Co., W. Va.

DATE REC'D BY LOCAL REGISTRAR Jan. 27, 1955
REGISTRAR'S SIGNATURE Walter L. Fraley M.D.
24. FUNERAL DIRECTOR Leryl Combs, ADDRESS Romney, W. Va.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 2 1955
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00062

00041 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Al[illegible] MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]rtland
LENGTH OF STAY (in this place) 6 yrs. 3mo. 19dy.
HOSPITAL OR INSTITUTION OR STREET ADDRESS X Sylva[illegible]reat

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible]land COUNTY Alleganx
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 12[illegible] Street

3. NAME OF DECEASED: (Type or Print) (First) Nellie (Middle) E. (Last) Platt

4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 19[illegible]

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: June 21, 1876

9. AGE last birthday [illegible] yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Sylvan Retreat Records, Cumberland, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	Cerebral Hyperemia	?
ANTECEDENT CAUSE (S) DUE TO (B)	Senile Arteriosclerosis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Hemorrhagic Nephritis	2 mos.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile Dementia	6 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 19[illegible] to Jan. 29 19[illegible], that I last saw the deceased alive on Jan. 29, 19[illegible], and that death occurred at 1130 P.M., from the causes and on the date stated above.

SIGNATURE [illegible]ulius E. [illegible]reau M.D. M. D. ADDRESS 49 Bruce St. DATE SIGNED 1-31-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Feb. 2, 1955

NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 2, 1955

REGISTRAR'S SIGNATURE Walter R. Franke M.D.

24. FUNERAL DIRECTOR ADDRESS Wm. H. Kight, Cumberland, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 19
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00063

00085

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton,
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): Myrtie D. Porter.

4. DATE OF DEATH: (Month) (Day) (Year): Jan. 16, 1955.

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married.

8. DATE OF BIRTH: March 16, 1885.

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Eckhart, Maryland.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Myers.

14. MOTHER'S MAIDEN NAME: Do not know.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-32-3023-B.

17. INFORMANT & ADDRESS: Oliver T. Porter.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) 490X Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Psychosis — Five Years

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1950, to Jan 16, 1955, that I last saw the deceased alive on Jan. 16, 1955, and that death occurred at 1130 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Paul A. Wilson M.D. Piedmont, W. Va. Jan. 18, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-19-55. — NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery, — LOCATION (City, town, or county) (State): Eckhart, Maryland.

DATE REC'D BY LOCAL REG. 1-18-55 — REGISTRAR'S SIGNATURE: Mrs Jane L. Lucky

24. FUNERAL DIRECTOR: J. J. Durst — ADDRESS: Frostburg, Md.

00066 00064

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 12 1/2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 65 E. Main St.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Rankin

4. DATE OF DEATH (Month) Jan. (Day) 8 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Jan. 27-1891

9. AGE last birthday: 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Zihlman, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Rankin

14. MOTHER'S MAIDEN NAME: Edith Matilda Shoemake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) W.W.1

16. SOCIAL SECURITY NO.: 213-10-9870

17. INFORMANT & ADDRESS: David Linn, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Shock from 1st, 2nd & 3rd degree burns of body	11 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) a fire in kitchen at his Apt.	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY: home

21c. (City or town) Frostburg (County) Allegany (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 7/55-3 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Fire of undetermined origion in his Apt. at home.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D.
DATE SIGNED: Jan. 8-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: I-10-1955
NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
LOCATION (City, town, or county): Frostburg (State) Md.

DATE REC'D BY LOCAL REG.: 1-10-55
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer
ADDRESS: Frostburg, Md.

RECEIVED
JAN 12 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00065

00042 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) 02 Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 959 Glenwood St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,
STREET ADDRESS (If rural give location) 959 Glenwood St.,

3. NAME OF DECEASED: (Type or Print) (First) CARRIE (Middle) VIOLA (Last) RICE

4. DATE OF DEATH: (Month) Jan. (Day) 17, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 15, 1875

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Hazen, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John S. Hendrickson

14. MOTHER'S MAIDEN NAME: Sarah J. Gordon

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mr. Ralph W. Rice 959 Glenwood St., Cumb. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval Between Onset And Death: Hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic Myocarditis. — 6 Yrs
DUE TO (c) Arteriosclerosis — 10 Yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1950, to 1-17, 1955, that I last saw the deceased alive on 1-16, 1955 and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
H W Ellison M.D. 126 Union St Cumberland Md

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/20/55 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 19, 1955 — REGISTRAR'S SIGNATURE Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00066

00043 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND LENGTH OF STAY (in this place) 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Pennsylvania Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 20 Pennsylvania Ave.

3. NAME OF DECEASED: (Type or Print) (First) Lilarein (Middle) May (Last) Riley

4. DATE OF DEATH: (Month) 1-29- (Day) (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: May 15, 1889

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bindery Work

10B. KIND OF BUSINESS OR INDUSTRY: Printing Bus.

11. BIRTHPLACE (State or foreign country): Magnolia, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Harris Steele Riley

14. MOTHER'S MAIDEN NAME: Sarah Eleanora Diggerstaff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Bruce Gorche, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2
IMMEDIATE CAUSE (A) Chronic Myocarditis 2 yrs

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/00/53, 19.., to 1/29/55, 19., that I last saw the deceased alive on 1/29/55, 19...., and that death occurred at 2:26 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Cumberland Md DATE SIGNED 1/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF I-31,55 NAME OF CEMETERY OR CREMATORY Rose Hill Cem. LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1955 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. 24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1955
BUREAU V. L.

Outside City Limits

MARYLAND 00086

00067

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Rural Cumberland
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Addt. - Mt. Savage Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Cumberland
STREET ADDRESS (If rural, give location) Homewood Addt. - Mt. Savage Rd,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Victor	Odell	Robertson	Jan	15	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
M	W	Married	July 9, 1883	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	General Contractors	Green Ridge, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Enos Robertson	Amanda Simms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	215-12-2565	Mrs. Abbie Robertson, Cumberland, Rt 1.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
334 X Immediate cause	(a) Apoplectic Stroke	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	1 year
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-14, 1955, to 1-15-, 1955, that I last saw the deceased alive on 1-14-, 1955, and that death occurred at 7:34 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] MD 5/ Green St 1-16-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 18. 1955	Hillcrest Burial Park	Cumberland Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 17. 1955	Walter K. Sauf, M.D.	John J. Hafer	Cumberland, Md.

MARGIN RESERVED FOR BINDING

Write corporate limits

00068

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00044

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 6/17/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole X
STREET ADDRESS (If rural give location) 148 West Street 1

3. NAME OF DECEASED: (Type or Print) (First) Myrtle (Middle) (Last) Roderick

4. DATE OF DEATH: (Month) (Day) (Year) January 4, 1955

5. SEX: F Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1/24/1889

9. AGE last birthday: 65 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Keyser, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph Hodges

14. MOTHER'S MAIDEN NAME: Annie Ryan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X
IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Chronic Osteo arthritis — ?
DUE TO (C) Diabetes Mellitus — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis — ?

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 17, 1954, to Jan. 3, 1955, that I last saw the deceased alive on Jan. 3, 1955, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE James G. McLean M. D. ADDRESS 49 Greene St. DATE SIGNED 1-4-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan. 6, 1955 — NAME OF CEMETERY OR CREMATORY Queens Point Cem — LOCATION (City, town, or county) Keyser, West Virginia (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 4, 1955 — REGISTRAR'S SIGNATURE Walter R. Hawtz, M.D.

24. FUNERAL DIRECTOR B. W. Markwood — ADDRESS Keyser W.Va.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 12 1955
BUREAU V

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1900069

00045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1 PLACE OF DEATH
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
MARYLAND
LENGTH OF STAY (In this place) 37 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 701 Piedmont Avenue

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 701 Piedmont Avenue 1

3. NAME OF DECEASED: (Type or Print) (First) HAROLD (Middle) DIPPEL (Last) ROEMMELMEYER

4. DATE OF DEATH: (Month) January (Day) 25 (Year) 1955

5. SEX Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married | 8. DATE OF BIRTH. Sept 18, 1888 | 9. AGE last birthday 66 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman | 10B KIND OF BUSINESS OR INDUSTRY: Standard Brands | 11. BIRTHPLACE (State or foreign country): Carbondale, Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Roemmelmeyer | 14. MOTHER'S MAIDEN NAME. Anna Dippel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 214-05-4380 | 17. INFORMANT & ADDRESS: Mrs. Julia Roemmelmeyer, Cumberland Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary Artery Dis.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Cholecystitis

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.20 ., 1954, to 1.25, 1955, that I last saw the deceased alive on 1.21, 1955, and that death occurred at 8a M, from the causes and on the date stated above.

SIGNATURE W.R. Williams M.D. ADDRESS Cumberland DATE SIGNED 1-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan. 27, 1955 | NAME OF CEMETERY OR CREMATORY Willow View Cemetery | LOCATION (City, town, or county) Carbondale, (State) Pennsylvani

DATE REC'D BY LOCAL REGISTRAR Jan 26, 1955 | REGISTRAR'S SIGNATURE Wm. R. Trautz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. DURRETT 00046 **CERTIFICATE OF DEATH** Reg. Dist. No. 00070 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY MINERAL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD
STREET ADDRESS (If rural give location) 85 X-3

3. NAME OF DECEASED: (Type or Print) (First) GILBERT (Middle) A. (Last) ROHRBAUGH

4. DATE OF DEATH: (Month) JANUARY (Day) 16 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: JANUARY 23 1870

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED farmer

10B. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony ROHRBAUGH

14. MOTHER'S MAIDEN NAME: Unknown SHOULDERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS. MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 48.1 (A) DUE TO Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 8 hrs

ANTECEDENT CAUSE (S) (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1955 to Jan. 15, 1955 that I last saw the deceased alive on Jan. 15, 1955, and that death occurred at 12:45A M, from the causes and on the date stated above.

SIGNATURE AND ADDRESS M. D. Cumberland - DATE SIGNED 1/16/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan. 18, 1955 | NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery | LOCATION (City, town, or county) (State) Fort Ashby, W. Va.

DATE REC'D BY LOCAL REGISTRAR Jan. 18, 1955 | REGISTRAR'S SIGNATURE Walter R. Haury M.D.

24. FUNERAL DIRECTOR AND ADDRESS William H. Kight, Cumberland, Md.

00087

00071 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Flintstone
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highway-route 40-17⅞ 8/10 miles east of Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pa. COUNTY Bedford
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Artemas
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)
Percy Cleveland Ruby	Jan. 1 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	single	March 23-1937	17 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer Hilton Mfg.Co at	Everett, Pa.	Chaneysville, Pa.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Percy A. Ruby	Belva Imes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	164-30-5487	Father-Percy A. Ruby, Artemas, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Contusion & subdural hemorrhage due to	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) fractured frontal bone, with severe lacerations	
	(c) of forehead and nose. (Auto accident)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)
	Highway #40	Near Flintstone (rural) Cumberland Allegany Md.

21d. TIME (Month) (Day) (Year) OF INJURY	(Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY Ooccur?
Jan. 1/55	4 A. M.		Driver-Rosemary Morton, thought she might have fallen asleep at the wheel and hit a culvert.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M. D. — M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED Jan. 1-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 4 1955	Fairview Christian Church Cem.	Englesmith, Pennsylvania

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 1, 1955	Nina L. Bender.	John J. Hafer	Cumberland, Md.

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2141 **CERTIFICATE OF DEATH** Reg. Dist. No. 00072 / 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
MARYLAND
LENGTH OF STAY (in this place)
62 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 101 Park St.,

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Victor (Last) Santelli

4. DATE OF DEAT (Month) Jan. (Day) 1, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Sept. 26, 1909

9. AGE Last birthday IF UNDER 1 YEAR / IF UNDER 24 HRS. 45 yrs. | Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Designer

10B. KIND OF BUSINESS OR INDUSTRY: Under Garment Fty.

11. BIRTHPLACE (State or foreign country): Cerisano, Cosenza, Italy

12. CITIZEN OF WHAT COUNTRY? Unite d Stat

13. FATHER'S NAME: Francesco Santelli

14. MOTHER'S MAIDEN NAME: Carolina Greco

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 065-01-3443

17. INFORMANT & ADDRESS: Mrs. Helen Santelli Cumberland, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Bronchopneumonia - Hypostatic	5 days
ANTECEDENT CAUSE (B)	DUE TO (B) Cerebral Hemorrhage	5 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Hypertension	5 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1954, to 1/1, 1955, that I last saw the deceased alive on 12/31, 1954, and that death occurred at 3:00 AM, from the causes and on the date stated above.

SIGNATURE H Bereaman M.D. ADDRESS Cumberland Md DATE SIGNED 1/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 1/4/55

NAME OF CEMETERY OR CREMATORY St. Patricks Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 3, 1955

REGISTRAR'S SIGNATURE Walter L. Fantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
JAN 12 1955
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00073

00047

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 16 Days
62. HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 830 Williams. St.

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) J. (Last) Schaffer

4. DATE OF DEATH (Month) Jan. (Day) 10 (Year) 1955

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: Nov. 2, 1882

9. AGE last birthday IF UNDER 1 YEAR Months IF UNDER 24 HRS Days Hours Min. 72 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Brick Plant

11. BIRTHPLACE (State or foreign country): Md. Cumberland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased Charles Schaffer

14. MOTHER'S MAIDEN NAME: Deceased Agnes McHugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-5223

17. INFORMANT & ADDRESS: Pt's chart---Nephew informant

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-30, 1954 to 1-10, 1955, that I last saw the deceased alive on 1-10, 1955, and that death occurred at 6:20 PM, from the causes and on the date stated above.

SIGNATURE Reza L. Baeni M.D. ADDRESS 62 Greene St Cumberland Md DATE SIGNED 1-11-55

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF I-13-55 | NAME OF CEMETERY OR CREMATORY Sts Peter & Paul Cem | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1955 | REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00074

00067

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
22 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
LENGTH OF STAY (in this place) 15 min.
61 HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Alleg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg X
STREET ADDRESS (If rural, give location) R.F.D. #2, Box 297 1

3. NAME OF DECEASED: (Type or Print) (First) Ruby (Middle) Lee (Last) Schriver
4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 1-10-1955
9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frostburg Miners Hospital, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm. Schriver
14. MOTHER'S MAIDEN NAME: Hazel Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Wm. Schriver, R.D. No. 2 Box 297 Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Prolonged delivery

ANTECEDENT CAUSE (B) DUE TO Presentation of Fetus in breech

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO extraction with asphyxiation & respiratory failure

(C)

INTERVAL BETWEEN ONSET AND DEATH 18 Min

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1955, to Jan 10, 1955, that I last saw the deceased alive on Jan 10, 1955, and that death occurred at 1:00 A M, from the causes and on the date stated above.

SIGNATURE Wm Lane M.D. ADDRESS Frostburg Md DATE SIGNED Jan 11 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-11-1955
NAME OF CEMETERY OR CREMATORY Memorial Park
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-12-55
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

VS. A15—10-53

20152224H6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00075

DR. REITER 00048 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FRIENDSVILLE
STREET ADDRESS (If rural give location) RFD #2

3. NAME OF DECEASED: (First) ROBERT (Middle) W. (Last) SELBY

4. DATE OF DEATH: (Month) JANUARY (Day) 26 (Year) 1955

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: JANUARY 8, 1955
9. AGE last birthday: yrs. Months Days 18 (IF UNDER 1 YEAR) Hours (IF UNDER 24 HRS.) Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND, Friendsville
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT V. SELBY
14. MOTHER'S MAIDEN NAME: BESSIE CAPEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.0
IMMEDIATE CAUSE (A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. atelectasis, left lung — ? days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 25, 1955, to Jan. 26, 1955, that I last saw the deceased alive on Jan. 26, 1955, and that death occurred at 10:34 P.M., from the causes and on the date stated above.
SIGNATURE O. A. Reiter M.D. ADDRESS M. D. 112 Bedford St. DATE SIGNED Jan. 26, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF 1/28/55
NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery Friendsville
LOCATION (City, town, or county) (State) Friendsville, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 26, 1955
REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.
24. FUNERAL DIRECTOR Jack D. Friend
ADDRESS Friendsville

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Wilson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00076

00068

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: 01 COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
LENGTH OF STAY (in this place) 49 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 102 Potomac St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport 43
STREET ADDRESS (If rural give location) 102 Potomac St

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Wesley (Last) Shaffer

4. DATE OF DEATH: (Month) Jan (Day) 1 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: 10 Oct 1869
9. AGE last birthday: 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) Engineer
10B. KIND OF BUSINESS OR INDUSTRY C & P Railroad
11. BIRTHPLACE (State or foreign country): Rowlesburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: William Shaffer
14. MOTHER'S MAIDEN NAME: Sophrona Mc Vicker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Carl W. Shaffer, Westernport, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 10, 1952, to Jan. 1, 1955, that I last saw the deceased alive on Dec. 31, 1954, and that death occurred at 8:30 A M, from the causes and on the date stated above.

SIGNATURE Paul R Wilson M.D. ADDRESS Piedmont W. Va DATE SIGNED Jan. 3, 1954

23. BURIAL, CREMATION, REMOVAL: (SPECIFY) Burial
DATE THEREOF Jan 4, 1955
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) (State) Westernport, Md

DATE REC'D BY LOCAL REGISTRAR 1-4-55
REGISTRAR'S SIGNATURE Mrs Jean C. Kelly
24. FUNERAL DIRECTOR ADDRESS E.S. Boor, Westernport, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00077

00049

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Rural
STREET ADDRESS (If rural give location): Bowling Green, R. F. D. #6,

3. NAME OF DECEASED: (First) Mary (Middle) Agnes (Last) Shaffer

4. DATE OF DEATH: (Month) 1- (Day) 20 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: April, 1894

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Deceased~~ William Mills

14. MOTHER'S MAIDEN NAME: ~~Deceased~~ Mary Barry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Patients chart. Sacred Heart Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSE (B) DUE TO: Hypertensive Cardio - Renal - Vascular Disease — 6 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO: Obesity

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, to Jan 20, 1955, that I last saw the deceased alive on Jan, 1955, and that death occurred at 6 09 M. from the causes and on the date stated above.

SIGNATURE AND ADDRESS OF M. D.: H. Devereaux MD Cumberland Md — DATE SIGNED: 1/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | DATE THEREOF: 1- 24-1955 | NAME OF CEMETERY OR CREMATORY: St. Patricks Cem. | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan 23, 1955 | REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

0005D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00078

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY GRANT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG, W.VA.
STREET ADDRESS (If rural give location) 104 N. MAIN STREET

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) A. (Last) SMITH

4. DATE OF DEATH: (Month) JAN. (Day) 5 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: 8/8/1876

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Stockman - Own Farm

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISSAC D. SMITH, Sr.

14. MOTHER'S MAIDEN NAME: MARY L. HARPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No

If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Chronic Nephritis (uremia) DUE TO

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic heart disease DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma prostate

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-, 1955, to 1-5-, 1955, that I last saw the deceased alive on 1-4-, 1955, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

SIGNATURE W.F. Williams M.D. ADDRESS Cumberland DATE SIGNED 1-5-55 MD

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan. 8, 1955

NAME OF CEMETERY OR CREMATORY Maplehill Cemetery

LOCATION (City, town, or county) (State) Petersburg, West Virginia

DATE REC'D BY LOCAL REGISTRAR Jan. 6, 1955

REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.

24. FUNERAL DIRECTOR J. Blaine Schaeffer

ADDRESS Petersburg, W. Va.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 12 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00079

00051

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 12 Valley St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
STREET ADDRESS (If rural give location): 12 Valley St.,

3. NAME OF DECEASED: (Type or Print) (First) HENRY (Middle) THOMAS (Last) SMITH

4. DATE OF DEATH: (Month) Jan. (Day) 27, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Feb. 13, 1882

9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired: Retired carpenter

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Peter D. Smith

14. MOTHER'S MAIDEN NAME: Mary D. Gormer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-9676

17. INFORMANT & ADDRESS: Mrs. Joseph A. Pohling Hagerstown, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

Immediate cause (a) Carcinoma of Lung

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15/54, to 1/27/55, that I last saw the deceased alive on 1/27/55, and that death occurred at 3:30 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jesse N. Frey Jr. M.D. 456 N. Centre St. 1/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/30/55 — NAME OF CEMETERY OR CREMATORY: St. Lukes Cem. — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 30, 1955 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
FEB 7 1955
BUREAU V. S.

Within corporate limits: DR. REITER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00080

00052

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
LENGTH OF STAY (in this place): 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
STREET ADDRESS (If rural give location): 504 SHERIDAN PLACE

3. NAME OF DECEASED: (First) PAMELA (Middle) S (Last) SMITH

4. DATE OF DEATH: (Month) JAN. (Day) 17 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: MAY 23 1952

9. AGE last birthday: 2 yrs. IF UNDER 1 YEAR: Months 6 Days IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: WALLACE SMITH

14. MOTHER'S MAIDEN NAME: JUNE STORM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT & ADDRESS: Wallace Smith - Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.1

IMMEDIATE CAUSE (A): Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (B) DUE TO: Acidosis — 4 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO: Gastroenteritis, acute — 5 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Anuria, Hyperpyrexia

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 12, 1955, to Jan 17, 1955, that I last saw the deceased alive on Jan 17, 1955, and that death occurred at 1:55 P M, from the causes and on the date stated above.

SIGNATURE: R. A. Reiter M. D. ADDRESS: 112 Bedford St. DATE SIGNED: January 17, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 1-19-55

NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 19, 1955

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Chas. L. George

ADDRESS: Cumberland, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00081

CERTIFICATE OF DEATH

00053 Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 270 E. Main St.

3. NAME OF DECEASED: (Type or Print) (First) Dorothy (Middle) (Last) Spates

4. DATE OF DEATH: (Month) Jan. (Day) 26 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 4/1/10
9. AGE last birthday: 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
KIND OF BUSINESS OR INDUSTRY: Teacher, Public School
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter E. Connor
14. MOTHER'S MAIDEN NAME: Nellie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Pt's Chart

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Terminal Hepatic failure	26 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Chronic Hepatitis, cause indet.	6 months
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1955, to Jan, 1955, that I last saw the deceased alive on Jan. 26, 1955, and that death occurred at 10:45 M, from the causes and on the date stated above.
SIGNATURE W. A. Van Buren M. D.
ADDRESS Cumberland, Md.
DATE SIGNED Jan. 27, 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Jan. 29, 1955
NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery
LOCATION (City, town, or county) (State) Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1955
REGISTRAR'S SIGNATURE Wirtes R. Lantz, M.D.
24. FUNERAL DIRECTOR J. R. Durst, Frostburg
ADDRESS

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00082

00088

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellerslie
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) W. (Last) Speelman

4. DATE OF DEATH (Month) (Day) (Year) Jan. 16, 1955

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 23, 1871

9. AGE Last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10B. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Speelman

14. MOTHER'S MAIDEN NAME: Bessie Tharp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Gertie Speelman, Ellerslie, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2
IMMEDIATE CAUSE (A) Chronic Myocardosis

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION.

19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to Jan 16, 1955, that I last saw the deceased alive on Jan 16, 1955, and that death occurred at 6 P M, from the causes and on the date stated above.

SIGNATURE John A Cooper M. D. ADDRESS Hyndman Pa DATE SIGNED Jan 17-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan. 19, 1955

NAME OF CEMETERY OR CREMATORY Porter Cemetery

LOCATION (City, town, or county) (State) Hyndman, Pa. RD1

DATE REC'D BY LOCAL REGISTRAR Jan 18 1955

REGISTRAR'S SIGNATURE J. Lloyd Wolfe

24. FUNERAL DIRECTOR ADDRESS Harvey H. Zeigler, Hyndman, Pa.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00083

00054 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH.
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland
LENGTH OF STAY (in this place) 42hrs.45min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) Jane Frazier Village-4-E.

3. NAME OF DECEASED: (Type or Print) (First) [redacted] (Middle) Stanley Langley (Last) Spencer

4. DATE OF DEATH: (Month) 1/ (Day) 17 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH: 1/15/55 | 9. AGE last birthday: yrs | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant | 10B. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): [redacted]. Cumberland Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard L. Spencer

14. MOTHER'S MAIDEN NAME: Eva Langley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Infant

17. INFORMANT & ADDRESS. Baby's Chart.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Hydrocephalus Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 d.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/16, 1955 to 1/17, 1955 that I last saw the deceased alive on 1/17, 1955, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Elizabeth Briggs M.D. ADDRESS 55 Greene St. Cumberland, DATE SIGNED 1/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/18/55 | NAME OF CEMETERY OR CREMATORY Alleg. County Cemetery | LOCATION (City, town, or county) Cumberland, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 18, 1955 | REGISTRAR'S SIGNATURE Winter R. Dantz, M.D. | 24 FUNERAL DIRECTOR John J. Hafer | ADDRESS Cumberland, Maryland

201518396

Within corporate limits 00055

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 00084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 146 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland 02

STREET ADDRESS (If rural, give location) 146 Bedford St. 1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bruce	P.	Straw	Jan.	25	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	June 6-1877	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Electrician	Potomac Ed. Co.	Clearfield Co. Pa.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Henry Straw	Emeline Bloom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	217-10-9466	(son) Cecil Straw, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (241X)	(a) Myocardial failure	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Chronic myocarditis also had	about 7 years
DUE TO		
	(c) Bronchial asthma with emphysema	"

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan. 25-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 28 1955	Hillcrest Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 26, 1955	Winter R. Frantz, M. D.	William N. Right	"

Within Corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00086

00056 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A1 — 10-53

1. PLACE OF DEATH.
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 South Waverly Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural give location) 1 So. Waverly Terrace

3. NAME OF DECEASED. (Type or Print) (First) ORRA (Middle) FRIEDA (Last) THOMAS

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Apr. 25, 1918

9. AGE last birthday 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10B KIND OF BUSINESS OR INDUSTRY: Cumb. News Agency

11 BIRTHPLACE (State or foreign country): Hampshire County, W.VA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES S THOMAS

14. MOTHER'S MAIDEN NAME: LAURA A WAGNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-7382

17. INFORMANT & ADDRESS: Mrs. Laura Thomas, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Diabetes Mellitus — 5 yrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M 21E INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950 to Jan. 31, 1955 that I last saw the deceased alive on Jan. 26, 1955, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

SIGNATURE AND M. D. Lloyd L. Barnett ADDRESS Cumberland DATE SIGNED 2/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Feb. 4, 1955 NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cem. LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 3, 1955 REGISTRAR'S SIGNATURE Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland, Maryland

RECEIVED
FEB 7 1915
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00085

00069 **CERTIFICATE OF DEATH** Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22
STREET ADDRESS (If rural give location) 14 Locust Street 1

3. NAME OF DECEASED: (Type or Print) George (First) Joseph (Middle) Tippen (Last)

4. DATE OF DEATH: (Month) Jan. (Day) 10th, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Sept. 12th, 1910

9. AGE last birthday: 44 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filteration

10B. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Tippen

14. MOTHER'S MAIDEN NAME: Clara Winebrenner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-6074

17. INFORMANT & ADDRESS: Mrs. Marguerite Tippen, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1592

IMMEDIATE CAUSE (A) DUE TO Carcinoma of Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH 12 mo

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Apr 9 1953

19B. MAJOR FINDINGS OF OPERATION Carcinoma of Sigmoid Colon

20. AUTOPSY? YES ☐ NO ☒

21. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 6, 1953, to Jan 10, 1955 that I last saw the deceased alive on Jan 10, 1955 and that death occurred at 11:30 M., from the causes and on the date stated above.

SIGNATURE Wm. Lane MD M. D. ADDRESS Frostburg Md DATE SIGNED Jan 11 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan. 13th, 55 — NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery — LOCATION (City, town, or county) Frostburg, — (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-13-55 — REGISTRAR'S SIGNATURE Mrs. Daisy V. Roe

24. FUNERAL DIRECTOR Joseph R. Durst, — ADDRESS Frostburg, Md.

00057 00087

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Died on arrival at the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (rural) Cumberland

STREET ADDRESS (If rural, give location) Brice Hollow Rd. R.F.D. #1 Old Town

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Rosa	Brooks	Twigg	Jan.	7	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	Widow	March 14-1885	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Rural-Brice Hollow Rd. near Twiggtown, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Elisha Huff	Jo Anna Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Mrs. Mabel B. Twigg, R.F.D. #1 Old Town, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	about 1 hr.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED Jan. 8-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 10, 1955	Flower Grove Cemetery	Near Oldtown, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 10, 1955	Wenker K. Hantz, M.D.	John J. Hafer, Cumberland, Md.	

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00088

DR. WEISMAN 00058

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 16 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 02
STREET ADDRESS (If rural give location) 186 WINEOW STREET 1

3. NAME OF DECEASED: (Type or Print) (First) WALTER (Middle) E. (Last) TWYMAN

4. DATE OF DEATH: (Month) JANUARY (Day) 14 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE. COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: November 29 1893

9. AGE last birthday 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Janitor

10B. KIND OF BUSINESS OR INDUSTRY: Ind. Families

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WALTER TWYMAN

14. MOTHER'S MAIDEN NAME: LENA CAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Acute Myocardial Failure DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Acute Myocardial Infarction DUE TO

(C) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH: 2 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21, 1954 to 1/14, 1955, that I last saw the deceased alive on 1/13, 1955, and that death occurred at 1:15 AM, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS Cumberland Md DATE SIGNED 1/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Jan. 17, 1955

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 14, 1955

REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00089

00089

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eckhart
LENGTH OF STAY (in this place) 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) GIACINTO (Middle) JOHN (Last) VALENZANO

4. DATE OF DEATH: (Month) Jan. (Day) 25, (Year) 1955

5. SEX male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: 2-10-1874

9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner

10B. KIND OF BUSINESS OR INDUSTRY: Consol. Coal Co.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Giacinto Valenzano

14. MOTHER'S MAIDEN NAME: Josephine Olivasso

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO 213-09-6584

17. INFORMANT & ADDRESS: Arthur Valenzano, Eckhart, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4443X
IMMEDIATE CAUSE (A) Hypostatic Con-Vrack — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (B) DUE TO Cancer 2 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Chronic Prostatitis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1955, to 1-25, 1955, that I last saw the deceased alive on 1-25, 1955, and that death occurred at 1 P. M, from the causes and on the date stated above.

SIGNATURE Dr. C. Grelis, M. D. ADDRESS Frostburg, Md. DATE SIGNED 1/27/55.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-28-55 | NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery | LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-28-55 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. ADDRESS

Within corporate limits 00059

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00090 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 1 yr.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 316 Park St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md. COUNTY: Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Cumberland

STREET ADDRESS (If rural, give location): 316 Park St.

3. NAME OF DECEASED: (Type or Print) (First) Richard (Middle) D. (Last) Wagner

4. DATE OF DEATH (Month) Jan. (Day) 30 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	single	Unknown	60 ? yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired.)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Fireman	B&O.R.Ry.	Cumberland, Md.	U.S.A.

13. FATHER'S NAME: Harry Gilmore Wagner

14. MOTHER'S MAIDEN NAME: Anna Elizabeth Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
yes W.W.I	220-10-7711	(sister) Georgie Wagner, R.F.D. #1 Cumberland, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral hemorrhage (apoplexy) — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED Jan. 31-1955

U. V. Devine M.D.

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 1, 1955	Rock Hill Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 1, 1955	Walter K. Brantz, M.D.	John J. Nafer,	" "

VS. A15A - 5 - 53

FEB 7 1955
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00091

CERTIFICATE OF DEATH

03070

Reg. Dist. No. 9

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Frostburg, Md. X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Floyd (Middle) (Last) Winebrenner

4. DATE OF DEATH: (Month) Jan. (Day) 13 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Feb. 7th, 1884
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Winebrenner
14. MOTHER'S MAIDEN NAME: Margaret Crowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Harvey Winebrenner, Rt. 2, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	Congestive Heart Failure, Rt.	3 days.
ANTECEDENT CAUSE (B) DUE TO	Chronic Heart Disease	2 to 3 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO	Arteriosclerosis, advanced	?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to Jan 13, 1955, that I last saw the deceased alive on Jan 13, 1955, and that death occurred at 5:45 P M, from the causes and on the date stated above.
SIGNATURE John B. Davis, M. D. ADDRESS Frostburg, Md. DATE SIGNED 1/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-16-1955
NAME OF CEMETERY OR CREMATORY Winebrenner Cemetery
LOCATION (City, town, or county) (State) Rt. 2, Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 1-16-55
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR Joseph R. Durst
ADDRESS Frostburg, Md.

VS. A15 — 10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59
11
60

60

70
59
11

RECEIVED
JAN 18 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00092

00090 **CERTIFICATE OF DEATH** Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cahlet. LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. No 1, Frostburg

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) R.D. No 1 Box 90

3. NAME OF DECEASED: (Type or Print) (First) Francis (Middle) Howard (Last) Winters
4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 1955
5. SEX: M
6. COLOR OR RACE: Wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 29-1895
9. AGE last birthday 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carlos Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James W. Winters
14. MOTHER'S MAIDEN NAME: Elizabeth Degarmoe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Frostburg, Md. Minnie Winters, R.D. No 1 (Carlos)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH 19 days.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary sclerosis. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Gastric dilation

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/6, 1955, to 1/25, 1955, that I last saw the deceased alive on 1/20/, 1955, and that death occurred at 11:30 A.M., from the causes and on the date stated above. [DOA]

SIGNATURE Frank T Harrat M. D. ADDRESS Frostburg Md. DATE SIGNED 1/26/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1-28-1955
NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-28-55
REGISTRAR'S SIGNATURE Dan. Davey N-Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

RECEIVED
FEB 3 1955
BUREAU V. S